



BlueCross BlueShield
of Kansas City

An Independent Licensee of the
Blue Cross and Blue Shield Association

**Non-Formulary and Other
Prior Authorization Request**

Please **fax** completed forms to **(816) 502-4915**

If you have any questions please call (816) 395-2176

Patient Name: _____ DOB: _____

BCBSKC ID (NOT SS#): _____

Medication: _____

Diagnosis: _____

Dose & Duration of Therapy: _____

Previous Therapy: _____

If you have any additional information pertinent to this patient's therapy, please specify or attach
medical office notes: _____

Physician Information – Please Print

Physician's Name: _____

BCBSKC 8-digit Provider # or NPI#: _____

Address: _____

Phone: _____ Fax: _____

Please allow two (2) business days from date of receipt of all necessary information for determination.
Duplicate submissions slow the process.

All patient information is strictly confidential.
Incomplete forms will be returned.